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STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
109 STATE STREET
MONTPELIER
05609-1001

February 4, 2002

Gloria J. Hurd, Executive Director
Vermont Board of Medical Practice
109 State Street
Montpelier, Vermont 05609-1106

In re: Robert S. Baska, M.D.
MPS 38-0501; MPS 39-0501; MPS 60-801

Dear Director Hurd:

Enclosed please find for filing with the Board the State's Amended Specification of Charges in the above-referenced matters. The original charges, filed on January 25, 2002, have been amended to correct several minor typographic or editing errors. Please see the explanatory footnote at the bottom of page 1 of the Specification of Charges. The amended charges should be read in concert with the State's earlier-filed Motion to Conduct Proceedings Pursuant to Protective Statutory Provisions.

I assume that Judge Dier will need to sign the amended charges, and I have included a signature line for this purpose. Please contact me on 828-5620 should you have any questions.

Sincerely yours,

JAMES S. ARISMAN
Assistant Attorney General

Enclosure

cc: Leighton C. Detora, Esq., Counsel for Respondent

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: Robert S. Baska, M.D.	)	Docket Nos.: MPS 38-0501
	)	MPS 39-0501; MPS 60-0801
	)	
	)	

AMENDED SPECIFICATION OF CHARGES

COMES NOW Petitioner, the State of Vermont, by and through Attorney General William H. Sorrell and undersigned counsel, and alleges[1] as follows:

1. Robert S. Baska, M.D. (Respondent) holds Vermont Medical License Number 042-0008460, issued on February 5, 1992. Respondent is a general surgeon, who formerly held privileges at Copley Hospital, Morrisville, Vermont. Respondent's Vermont license to practice medicine is currently suspended.

2. Jurisdiction vests in the Vermont Board of Medical Practice (Board) by virtue of 26 V.S.A. §§1353, 1354, 1355-1361 & 1398 and 3 V.S.A. §§129, 129a & 809-814.

I. Background.

3. The Vermont Board of Medical Practice opened two complaints against Respondent in May 2001, one filed by a female patient of Respondent, and the other complaint based on information indicating that significant restrictions had been placed on Respondent's clinical privileges at Copley Hospital. The Board conducted a preliminary investigation of the circumstances involved in these complaints. Following this investigation the assigned Board investigating committee recommended to the Office of the Attorney General that a motion be filed seeking immediate emergency summary suspension of

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1. The charges against Respondent Baska are amended herein to correct typographic and/or editing errors as follows: 3rd line, page 5: correct spelling of word bandemia; 4th line, page 8: correct phrase to read: "percutaneous nephrostomy with a further left nephrectomy planned"; 10th line, page 13: correct and renumber second paragraph "36" and each numbered paragraph thereafter. February 4, 2002.

Respondent's medical license to protect the health, safety, and welfare of patients and the Vermont public.

4. The State of Vermont on August 9, 2001 filed a Motion for Summary Suspension of Respondent Baska's license to practice medicine, alleging that the continued practice of medicine by Respondent was contrary to the best interests of patients, the public, and the medical profession.[2] On August 10, 2001, immediately prior to the emergency hearing on the State's motion, Respondent agreed to summary suspension of his medical license pending further proceedings before the Board. Respondent also agreed to cease and desist from any and all practice of medicine in the State of Vermont or elsewhere until further order of the Board.

5. On November 7, 2001 Respondent filed a pleading styled as "Motion to Lift Summary Suspension". Respondent's motion claimed "changed circumstances" as justifying removal of the Board's order of summary suspension. The State opposed Respondent's motion, arguing that an evidentiary hearing on the serious allegations of repeated unprofessional conduct by Respondent was required to protect the health, safety, and welfare of the public and patients. By order dated December 19, 2001 the Board denied Respondent's motion to lift the summary suspension of his medical license.

II. Unprofessional Conduct of Respondent.

6. Respondent Robert S. Baska, M.D., has engaged in conduct that is immoral, unprofessional, and/or dishonorable in the practice of medicine, as set forth below. Respondent's surgical outcomes and post-operative involvement with patients demonstrates a lack of care, sound judgment, and/or concern regarding possible complications and the well-

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2. The State's summary suspension motion and exhibits were sealed on the State's motion, pursuant to 26 V.S.A. § 1360(c) (protection of identity of victim and medical records) and §1443(c) (protection of peer review information).

being of his patients. Respondent's surgeries were carried out with a rapidity that indicates a lack of care, prudence, and attention to detail during these procedures. Many patients experienced major blood loss that should have been preventable.

Patient A

7. Patient A filed a complaint with the Vermont Board of Medical Practice on or about May 24, 2001 regarding Respondent Baska. Respondent had previously provided surgical and other medical care to Patient A for a period of years. Patient A suffers from serious health problems that have required continuing medical care and repeated hospital admissions. Respondent first began to provide medical care to Patient A in 1993. Medical care of the patient by Respondent continued thereafter, as did the physician-patient relationship between them. Respondent provided surgical and medical care to Patient A as late as March 2001.

8. Over time the relationship between Patient A and Respondent became increasingly personal, beginning in 1997. Patient A was Respondent's patient at this time. Beginning in 1997 and continuing until late 2000 Patient A and Respondent were involved together in an ongoing relationship that included meeting, socializing, and engaging in a close personal and sexual relationship which included intercourse and/or sexual activity on a repeated basis. The relationship included instances of socializing and personal communication which occurred outside a medical setting and which were not for medical purposes. During this relationship Respondent gave Patient A gifts of jewelry and clothing. Respondent asked Patient A to hide the relationship because he was married at the time. For the period of time in question, there is no written record that Respondent ever transferred care of Patient A to another doctor.

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9. The relationship between Patient A and Respondent Baska included sexual contact and/or sexual intercourse between Respondent and Patient A on more than one occasion, while the doctor-patient relationship existed between the two. After the continuing personal and intimate relationship between the two ended in late 2000 at least one additional act of sexual contact nonetheless occurred in early 2001 between Patient A and Respondent, coinciding with surgery that Respondent performed on the patient.

10. Sexual contact and/or socializing between Respondent and Patient A occurred on or about dates that can be correlated with one or more admissions of Patient A to Copley Hospital, with Respondent Baska being listed as the admitting physician. Between July 1998 and as late as February 2001, such events are closely linked in time.

11. On at least one occasion Respondent engaged in sexual intercourse with Patient A in her hospital room, after having been the admitting physician for her care. Such incident occurred on or about August 8, 1998.

12. Respondent engaged in conduct with Patient A that is contrary to the AMA Code of Medical Ethics, § 8.14, Sexual Misconduct in the Practice of Medicine, which provides, "Sexual contact that occurs concurrent with the physician-patient relationship constitutes sexual misconduct."

13. Respondent Baska engaged in a pattern of serious and recurring violations of professional boundaries involving his patient. By Respondent's actions exploited the trust, knowledge, and/or emotions that Patient A developed toward him during the physician-patient relationship and unduly influenced the patient's decision making.

14. Notwithstanding the above circumstances, Respondent performed a repeat resection of Patient A's ilco-colonic anastomosis in March 2001. The pathology tissue report did not support the need for major bowel resection for suspected recurrent Crohn's disease.

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Moreover, Patient A was placed in grave, life-threatening danger by surgical complications which Respondent did not recognize and properly respond to. Post-operatively Patient A suffered from a distended abdomen, abdominal pain, plural effusion, bandemia with an elevated white blood count, and acute respiratory distress. Patient A lost approximately half her blood during a very rapidly performed operation that lasted only about 25 minutes, raising questions as to whether Respondent carried out this procedure with proper care. Respondent failed to note post-operative signs of intra-abdominal infection that were not subtle. He failed to utilize a CT scan to identify the source of Patient A's potentially life-threatening complications and respond to these. Patient A subsequently required transfer to Dartmouth Hitchcock Medical Center where she underwent a prolonged and complicated course for drainage of a pelvic abscess. Respondent's failure to properly respond to Patient A's post-surgical complications contributed to the ultimate severity of these complications.

15. In late 2001 Respondent approached Patient A and stated that he wanted to apologize to her for his past treatment of her. In so doing, Respondent told Patient A that his greatest thrill had been to take her to the brink of death and back again.

Patient B.

16. Respondent performed surgery in October 2000 on Patient B, a woman in her 40s, who underwent a sigmoid resection for chronic diverticulitis. Subsequent pathological examination of the bowel showed no active or chronic inflammatory change. The pathology report noted diverticulosis, not diverticulitis. The surgery performed by Respondent was not clearly indicated or substantiated by pathology results. Patient B lost a great quantity of blood during a very rapidly performed operation. Patient B's temperature was elevated post-operatively. Her hematocrit fell to 22 percent from a pre-surgical value of 46 percent.

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Patient B's white blood cell count was in excess of 36,000 prior to discharge, and she had an ileus pattern.

17. The development of a post-surgical intra-abdominal abscess is a recognized possible complication of the surgery that Respondent performed. Nonetheless, Respondent discharged the patient with an elevated white count, without sufficient evaluation, and without a clear plan for how her condition would be followed. Respondent did not pursue the possibility of a pelvic abscess by ordering a CT scan. Patient B later had to be transported to Fletcher Allen Health Care and was treated there for a serious pelvic abscess.

18. Respondent during his verbal communications with Patient B regarding her surgery showed indifference to her complaints of pain and little interest regarding her post-surgical outcome. On one occasion he made a crude and demeaning remark to Patient B regarding her bodily functions. During subsequent visits in late-2000 and early 2001, Respondent also made inappropriate and/or crude remarks to Patient B during an examination for a suspected hernia, including comments that "God is not listening to you anymore", "maybe a bolt of lightning will hit the [operating] table while you're in the OR and strike you dead", and "I'll fix it [the hernia] so that when you get to Hell . . . it won't be bothering you." Respondent's words and manner showed a lack of respect and regard for Patient B and a lack of concern for her well-being.

Patient C.

19. Respondent performed a sigmoid resection for chronic diverticulitis on Patient C in March 2001. Patient C was a woman in her 70s. The post-surgical pathology report noted an essentially normal colon, with diverticulosis and no inflammation. The

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patient was in decline from the time of surgery. Both her hemoglobin and hematocrit became significantly low. The patient had lost substantial blood during surgery. Moreover, post-operatively Patient C had repeated bloody bowel movements, and required approximately 12 units of blood. On one occasion, within a period of hours, Patient C lost nearly two liters of blood from her rectum. Respondent was aware of patient's condition but failed post-operatively to properly investigate her persistent blood loss and rectal bleeding. Such failed post-operative management contributed to the patient's death by hemorrhagic shock. Respondent failed to properly note, diagnose, and treat Patient C's post-surgical complications, decline, and blood loss.

Patient D.

20. Respondent operated on Patient D, a woman in her 30s with a lengthy history of Crohn's disease, in March 2001. Such surgery was for removal of a retained rectal stump and closure of a recto-vaginal fistula and was completed by Respondent in only about 106 minutes. Fletcher Allen Health Care surgeons had seen Patient D previously and had not elected to perform such surgery. Following the surgery by Respondent, a preliminary verbal pathology report to him by the pathologist indicated that there might be a segment of patient's ureter in the removed specimen. Respondent, however, did not diagnostically pursue such a possibility. Stents had not been used by Respondent during surgery to increase identification and protection of the patient's urinary system, in response to the known risk of the surgery that was being performed by Respondent.

21. Respondent failed to respond properly to Patient D's post-surgical complications and properly treat these complications. Patient D's post-operative course was marked by prolonged ileus and urinary retention. Patient D was discharged 10 days after

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surgery, without appropriate diagnostic tests, although significant volumes of hazy yellow liquid had been noted coming from the perineal wound. Later, Patient D was admitted to Fletcher Allen Health Care where a transected ureter was diagnosed. Thereafter, Patient D was treated with a percutaneous nephrostomy with a further left nephrectomy planned to be performed later.

Patient E.

22. Respondent operated on Patient E, a male in his 60s with a massive scrotal hernia, in November 1999. The patient had a 30-year medical history related to this condition. According to a Fletcher Allen discharge summary, Patient E had been turned down twice earlier for a left inguinal hernia (LIH) surgical repair at that institution. Respondent, however, made the decision to operate on Patient E for reduction and repair the LIH and resection of a hydrocele. Such surgery presented substantial risk to this patient in light of his history and condition. Respondent made an incision in the left groin and down to the hernia sac, the contents of which consisted of fluid, plus the large and small bowel. Respondent's attempt to reduce these contents required an extension of the incision into the abdomen.

23. Respondent's attempts to place the herniated viscera back into the abdominal cavity resulted in overfilling of the abdomen and a marked increase in intra-abdominal pressure. Respondent sutured a large sheet of prosthetic mesh in attempt to close the surgical opening over the bowel. However, Patient E had to be transferred to Fletcher Allen Health Care the same day. Patient E required resuscitation before efforts could be undertaken to revise the surgery that Respondent had performed earlier. When Patient E was taken to the operating room he was found to have necrotic large bowel at sigmoid

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anastomosis. Resection of the bowel was carried out, and the bowel that had earlier been taken from the hernia sack by Respondent now had to be returned to the hernia sack. Four clays after admission to Fletcher Allen systemic inflammatory response syndrome/sepsis appeared. Thereafter, the patient suffered continual decline and died 8 days after the Fletcher Allen admission, following withdrawal of life support by his family.

Patient F.

24. Respondent operated on Patient F, a woman in her late-30s in February 2000 and performed an uneventful laparoscopic cholecystectomy upon her. The patient was discharged the same day. Subsequently, Respondent failed to properly respond to and treat Patient F's post-surgical complications. Six days after being discharged Patient F returned to the hospital and was admitted, appearing ill and complaining of left lower quadrant abdominal pain. Patient F had a white blood count of 13,700. However, Respondent did not order a liver function test, CT scan, or other evaluative procedures. An X-ray done at the time showed no evidence of ileus. Nonetheless, Respondent merely assessed Patient F's condition as postoperative ileus and discharged her.

25. Following significant pain which lasted for several clays, Patient F was sent to Fletcher Allen Health Care to be evaluated for a possible bile leak. There, Patient F was surgically explored and bile was drained. Patient F later became hemodynamically unstable, and she was placed on a ventilator due to concerns regarding possible acute respiratory distress. Patient F required hospitalization at Fletcher Allen for two weeks before she could be discharged. Respondent's failure to properly respond to and treat Patient F's post-surgical complications contributed to her unnecessarily prolonged and difficult course of recovery.

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Patient G.

26. Patient G, a woman in her mid-30s, underwent a hysterectomy by another surgeon in February 1998. In less than one week following surgery she returned to the Copley Hospital emergency room with nausea, distension, and abdominal pain, with a white blood count of 5,400, and with 30 bands (bandemia). Patient G was admitted. Respondent's subsequent care of Patient G failed to recognize and properly respond to her post-surgical complications.

27. Respondent and another doctor examined Patient G and assessed her as dehydrated with ileus. No vaginal exam was performed, notwithstanding the patient's surgery less than one week earlier. Within hours Patient G's temperature rose to almost 103 degrees, her pulse rate was 130, and stool was coming from her vagina.

28. Patient G was taken to the operating room, and Respondent performed a Hartman procedure after finding stool in her vagina. During surgery Respondent also found a hole in Patient G's rectum and stool in her abdomen. The patient had a lengthy hospital stay and shortly before discharge developed a burning sensation on urination, indicating a possible bladder infection or abscess. In fact, urinalysis indicated that Patient G did not have a bladder infection. Her temperature was approximately 103.5, pulse was rapid (114), and her white blood count was 13,500 (against a 3.9 post-surgical blood count). Nonetheless, Patient G was merely given antibiotics and discharged. Thus, Respondent failed to recognize and properly respond to the post-surgical complications that Patient G was experiencing.

29. Patient G returned to the hospital the next day with a distended abdomen and suffering general malaise. A CT scan located a pelvic abscess and a subdiaphragmatic

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abscess. Patient G was transferred to Fletcher Allen and, later, Dartmouth Hitchcock. Patient G was in danger of dying. Her white blood count reached 25,000 at Dartmouth Hitchcock. Patient G underwent a lengthy recovery and was later discharged.

Disruptive and/or Inappropriate Conduct

30. In repeated incidents dating back to 1998 Respondent exhibited disruptive, inappropriate, and/or offensive personal behavior, comments, and conduct toward hospital staff and patients. His conduct demonstrated poor anger control and an inability to conform his conduct to reasonable standards in a medical setting. His conduct included instances of verbal abuse and demeaning remarks to hospital staff and/or patients. Among such occurrences are the following: in November 1998 Respondent made crude, inappropriate, and unwanted remarks to a female patient, comparing the behavior of men to dogs and that of women to cats and stating that in his next life he wished to be a "porn star" named "Bolt Upright". The patient was disturbed and upset by such remarks. In another incident, in February 2000, Respondent stated regarding a female patient in his care that he remembered "working on [her] ass" during an earlier surgical procedure. The patient's mother and another individual were present at the time of this remark, and the patient felt embarrassed and humiliated by Respondent's crude observation.

31. In March 2000 Respondent reacted angrily upon learning that a nurse had received an order for medication for one of Respondent's patients from a consulting physician. Respondent objected to this, loudly exclaimed, threw a chart, and slammed a door. He returned in a few minutes and repeatedly and loudly banged on the door and again spoke angrily with the nurses. Those present expressed fear and concern for their personal safety after the incident because of Respondent's angry and explosive behavior.

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Also in March 2000, Respondent complained to the husband of a woman in labor about having to be at the hospital at 4:00 a.m. During conversation with the husband Respondent threatened to leave and not assist with the wife's C-section delivery. Later, when the husband approached Respondent to discuss the situation and make amends, Respondent told him, "I don't want to talk to you."

32. In April 2000 Respondent became upset when asked to come to the hospital when a patient was found to have stool coming from an incision. Respondent came to the hospital and verbally attacked hospital staff and spoke of them in a demeaning manner, characterizing the nursing staff as incompetent and a "joke to the profession". In August 2000 at the start of a surgical procedure Respondent lost control and twice threw surgical instruments across the operating room.

33. In September 2000 Respondent displayed rage, abusive behavior, and profane language to staff in response to apparent confusion as to whom should have been notified about a serious change in a patient's condition. Respondent believed that it was clear he was to be notified and became angry with hospital and nursing staff. He shouted profanities at length, punched the air and a wall, and slammed a chair on the floor. Respondent's angry behavior lasted for approximately 20 minutes. He appeared unable to control his angry mood or conduct. Respondent's outburst was focused on his own needs and only peripherally on the needs of the patient who was in crisis and his family.

34. On two or more occasions, between February and July of 2001, Respondent threatened to harm administrative officers of Copley Hospital. Specifically, Respondent threatened to shoot a hospital administrator. The targets of such threats by Respondent were placed in fear for their personal safety and for the safety of their families.

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III. Statutory Violations.

Count 1.

35. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

36. By two or more acts related to care of Patient A, described in Paragraphs 7 through 14, above, Respondent in the course of practice failed to use and exercise on repeated occasions, that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions. 26 V.S.A. § 1354(22); 3 V.S.A. § 129a(a)(10).

Count 2.

37. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

38. By two or more acts related to care of Patient A, described in Paragraphs 7 through 14, above, Respondent engaged in unprofessional conduct in that in the course of practice, he grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions. 26 V.S.A. § 1354(22); 3 V.S.A. § 129a(a)(10).

Count 3.

39. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

40. By one or more acts related to the care of Patient A, as described in Paragraphs 7 through 13, above, Respondent engaged in unprofessional conduct in that his conduct evidenced unfitness to practice medicine. 26 V.S.A. § 1354(7).

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Count 4.

41. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

42. By one or more acts related to the care of Patient A, as described in Paragraphs 7 through 13, above, Respondent engaged in unprofessional conduct in that on one or more occasions his conduct evidenced a failure to comply with 18 V.S.A. § 1852, the Patient's Bill of Rights. 26 V.S.A. § 1354(24); 3 V.S.A. § 129a(a)(3).

Count 5.

43. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

44. By one or more acts related to the care of Patient A, as described in Paragraphs 7 through 14 (Patient A), Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 6.

45. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

46. By one or more acts related to the care of Patient A, as described in Paragraphs 7 through 14, above, Respondent exercised undue influence on or took improper advantage of a person who was using his professional services. 3 V.S.A. § 129a(a)(11).

Count 7.

47. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

48. By one or more acts related to the care of Patient D, as described in Paragraphs 20 and 21, above, Respondent engaged in unprofessional conduct in that in the course of practice, he grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful,

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careful and prudent physician engaged in similar practice under the same or similar conditions. 26 V.S.A. § 1354(22).

Count 8.

49. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

50. By one or more acts related to the care of Patient E, as described in Paragraphs 22 and 23, above, Respondent engaged in unprofessional conduct in that in the course of practice, he grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions. 26 V.S.A. § 1354(22).

Count 9.

51. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

52. By one or more acts, as described above in Paragraph 18 (Patient B), Respondent engaged in unprofessional conduct in that his conduct evidenced unfitness to practice medicine. 26 V.S.A. § 1354(7).

Count 10.

53. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

54. By one or more an acts, as described above in Paragraph 18 (Patient B), Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 11.

55. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

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56. By one or more acts, as described above in Paragraph 18 (Patient B), Respondent engaged in unprofessional conduct in that he engaged in conduct which evidenced a failure to comply with 18 V.S.A. § 1852, the Patient's Bill of Rights. 26 V.S.A. § 1354(24); 3 V.S.A. § 129a(a)(3).

Count 12.

57. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

58. By one or more acts, as described above in Paragraph 30 (Disruptive and/or Inappropriate Conduct), Respondent engaged in unprofessional conduct in that his conduct evidenced unfitness to practice medicine. 26 V.S.A. § 1354(7).

Count 13.

59. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

60. By one or more an acts, as described above in Paragraph 30 (Disruptive and/or Inappropriate Conduct), Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 14.

61. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

62. By one or more acts, as described above in Paragraph 30 (Disruptive and/or Inappropriate Conduct), Respondent engaged in unprofessional conduct in that he engaged in conduct which evidenced a failure to comply with 18 V.S.A. § 1852, the Patient's Bill of Rights. 26 V.S.A. § 1354(24); 3 V.S.A. § 129a(a)(3).

Count 15.

63. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

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64. By one or more acts, as described above in Paragraph 31 (Disruptive and/or Inappropriate Conduct), Respondent engaged in unprofessional conduct in that his conduct evidenced unfitness to practice medicine. 26 V.S.A. § 1354(7).

Count 16.

65. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

66. By one or more acts, as set forth above in Paragraph 31 (Disruptive and/or Inappropriate Conduct), Respondent engaged in unprofessional conduct in that his conduct evidenced a failure to comply with 18 V.S.A. § 1852, the Patient's Bill of Rights. 26 V.S.A. § 1354(24); 3 V.S.A. § 129a(a)(3).

Count 17.

67. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

68. By one or more acts, as described above in Paragraph 31 (Disruptive and/or Inappropriate Conduct), Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 18.

69. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

70. By one or more acts, as set forth above in Paragraph 32 (Disruptive and/or Inappropriate Conduct), Respondent engaged in unprofessional conduct in that his conduct evidenced unfitness to practice medicine. 26 V.S.A. § 1354(7).

Count 19.

71. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

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72. By one or more acts, as described above in Paragraph 32 (Disruptive and/or Inappropriate Conduct), Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 20.

73. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

74. By one or more acts, as set forth above in Paragraph 33 (Disruptive and/or Inappropriate Conduct), Respondent engaged in unprofessional conduct in that his conduct evidenced unfitness to practice medicine. 26 V.S.A. § 1354(7).

Count 21.

75. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

76. By one or more acts, as described above in Paragraph 33 (Disruptive and/or Inappropriate Conduct), Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 22.

77. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

78. By one or more acts, as set forth above in Paragraph 34 (Disruptive and/or Inappropriate Conduct), Respondent engaged in unprofessional conduct in that his conduct evidenced unfitness to practice medicine. 26 V.S.A. § 1354(7).

Count 23.

79. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

80. By one or more acts, as described above in Paragraph 34 (Disruptive and/or Inappropriate Conduct), Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

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Count 24.

81. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

82. By one or more actions, as described above in Paragraphs 7 through 34, Respondent engaged in unprofessional conduct in that in the course of practice he engaged in conduct that evidenced unfitness to practice medicine. 26 V.S.A. § 1354(7).

Count 25.

83. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

84. By one or more actions, as described above in Paragraphs 7 through 34, Respondent engaged in immoral, unprofessional, and/or dishonorable conduct. 26 V.S.A. § 1398.

Count 26.

85. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

86. By two or more actions, as described above in Paragraphs 7 through 34, Respondent engaged in unprofessional conduct in that in the course of practice, he failed to use and exercise on repeated occasions that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient occurred. 26 V.S.A. § 1354(22); 3 V.S.A. § 129a(10).

Count 27.

87. Paragraphs 7 through 34, above, are repeated and incorporated by reference.

88. Alternatively, Respondent's conduct, as described above in Paragraphs 7 through 34, includes a gross failure to use and exercise on at least one occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful

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and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient occurred. 26 V.S.A. § 1354(22); 3 V.S.A. § 129a(10).

WHEREFORE, Petitioner, the State of Vermont, moves the Board of Medical Practice to condition, limit, suspend, or REVOKE the medical license of Respondent Robert S. Baska, M.D., or take such other disciplinary action as the Board may deem proper.

Amended Charges Dated at Montpelier, Vermont this 4th day of February, 2002.

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

By: James S. Arisman
JAMES S. ARISMAN
Assistant Attorney General

Foregoing Amended Charges Issued: _____
HON. HILTON H. DIER, JR.
Secretary, Board of Medical Practice

Signed and Dated at Montpelier, Vermont this 6th day of February, 2002.

Office of the
ATTORNEY
GENERAL
109 State Street
Montpelier, VT
05609